Meeting Minutes
Health Information Technology Council Meeting

June 9, 2014
3:30 – 5:00 P.M.

One Ashburton Place, 21th floor Matta Conference Room
Boston, MA

Meeting Attendees

Name	Organization	
John Polanowicz	*(Chair) Secretary of the Executive Office of Health and Human Services*	Y
Manu Tandon	*(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	y
William Oates	*Chief Information Officer, Commonwealth of Massachusetts*	*
David Seltz	*Executive Director of Health Policy Commission*	**
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	N
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Y
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	N
Patricia Hopkins MD	*Representative from a small Physician group Practice Rheumatology & Internal Medicine Doctor (Private Practice)*	Y
Meg Aranow	*Senior Research Director, The Advisory Board Company*	Y
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Y
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	Y
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	N
Jay Breines	*Executive Director, Holyoke Health Center*	N
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Y
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	Y
Margie Sipe, RN	*Performance Improvement Consultant, Massachusetts Hospital Association (MHA)*	Y
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	Y
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	Y
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Y
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Y
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Y
Kristin Thorn	*Acting Director of Medicaid*	Y

*Claudia Boldman – in for William Oats

** Iyah Romm – in for David Seltz

Guest

Name	Organization	
Robert McDevitt	EOHHS	Y
Nick Welch	EOHHS	Y
Stacy Piszcz	EOHHS	Y
Kathleen Snyder	EOHHS	Y
Amy Caron	EOHHS	N
Jennifer Monahan	MAeHC	Y
Micky Tripathi	MAeHC	Y
Mark Belanger	MAeHC	Y
Ashlie Brown	EOHHS	N
Kris Williams	EOHHS	Y
Pam May	Partners	N
Lisa Fenichel	Consultant	Y
Jessica Costantino	AARP	Y
Sarah Moore	Tufts MC	Y
David Smith	MA Hospitals	Y
David Bachard	NEQCA	Y
David Bowditch	EOHHS	Y
Darrel Harmer	EOHHS	Y
Rick Wilson	EOHHS, Office of Medicaid	Y
Laura Nasuti	MDPH	Y
Jim Nally	EOHHS	Y
Adrian Gropper	MMS	Y
Linda Vaitkus	EOHHS	Y
Patricia Daly	DPH	Y
Cecilia Gerard	HPC	Y

Meeting called to order – minutes approved

The meeting was called to order by Secretary Polanowicz at 3:31 P.M.

The Council reviewed minutes of the May 5, 2014 HIT Council meeting. The minutes were approved as written.

Discussion Item 1: Leveraging the Mass HIway for Public Health (Slides 3-30)

See slides 3-30 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Laura Nasuti, Deputy Director, Office of Statistics and Evaluation at the Massachusetts Department of Public Health (MDPH), presented on Leveraging the Mass HIway for Public Health – MDPH's Investment in the HIway.

(Slide 4) Introduction – Public Health reporting is one of the main drivers for use of the HIway.

(Slide 5) Agenda – The presentation will cover the importance of connecting to the HIway, the timeline for the different nodes and deployment, overview of the different nodes on the HIway, and the impact on the MDPH and future work.

(Slide 6) MDPH & HIway – The nodes will support and improve the goals of public health, often providing administrative simplification, and in some cases, increasing the security of data transmission. Some of these nodes will support stage 1 and stage 2 meaningful use attestations.

(Slide 7) Timeline for DPH HIway Nodes – Massachusetts Immunization Information System (MIIS), Syndromic Surveillance (SS) Electronic Lab Reporting (eLR), and the Massachusetts Cancer Registry (MCR) all satisfy stage 1 and 2 attestations. The last three on the slide [Intake Enrollment and Assessment Transfer Service (IEATS), Childhood Lead Poisoning Prevention Program (CLPPP), e-Referral] are nodes that evolved because there was a program need for them.

(Slide 8) DPH HIway Node: Massachusetts Immunization Information System (MIIS)- MIIS is the most well-known HIway node. The objective is to improve the submission process of immunization records. A before and after picture of the submission process was provided.

(Slide 9) DPH HIway Nodes: MIIS – MIIS benefits are administrative simplification, increased security of data transmission, and data reliability. The hope is that this will also decrease the prevalence of double immunizations in the Commonwealth. MIIS submission satisfies stage 1 and 2 of meaningful use. There are 13 established interfaces representing 175 provider sites. An additional 10 are in testing. 75-100 organizations need to connect representing around 1600 providers including healthcare professionals, Young Men's Christian Association (YMCA) programs, schools, Women Infants and Children (WIC) programs, and any other programs that help administer vaccinations.

- Comment (Secretary Polanowicz): On each of the seven nodes, which do we have regulations in place for? How many are push and how many are pull? It would be good to tie this conversation into the different grants.
    - Answer (Laura Nasuti): I know there is mandatory reporting into MIIS, but I am not sure if it requires use of the HIway? For instance e-referral is not a regulation, it is a new program.
    - Answer (Darrel Harmer): I do not believe it does, we are requiring usage through policy I do not think we have regulations.

(Slide 10) DPH HIway Nodes: MIIS – The biggest challenge was that there is no single standard and we needed everyone to send the same type of message and get everyone reporting to MIIS via the HIway. We continue to work with vendors to get them connected to the HIway and outreach to providers for meaningful use.

- Comment (John Halamka): Standards were created at the federal level with zero specificity about how you get this information to MDPH. We have been using smoke signals and Morse code because we are unable to get consensus. What we want to do is standardize transport and leverage that for Public Health.
- Question (Laurance Stuntz): Any thought to sending immunizations from the registry out to other physicians or other data sources?
    - Answer (Darrel Harmer): At this point we are really focusing on replacing current connections with the Mass HIway. Once that is complete we will look at opening it up.
- Comment (John Halamka): We [BIDCO] are the pilot for the [MDPH] consent roll out. The state made the decision that instead of opt in, it's an opt out consent. DPH has the right to access the data, but not share it.

(Slide 11) DPH HIway Nodes: Syndromic Surveillance (SS) – Syndromic Surveillance supports stages 1 and 2 meaningful use. You can submit the chief complaint from the Emergency Department (ED) so that it can be sent via the HIway to BioSense. (Note: The BioSense program is a public health surveillance system run by the Centers for Disease Control and Prevention (CDC).

(Slide 12) DPH HIway Nodes: SS - The Syndromic Surveillance program supports a nationwide initiative and the HIway offers a single and secure method for reporting. Impact is really seen at the ED which must send data to BioSense. The node is in live production.

(Slide 13) DPH HIway Nodes: SS – The challenge is that the CDC came out with new validation requirements which prevented some providers from submitting data. A MDPH letter was sent to providers saying they are engaged with testing and validation. Next step in the process is to implement the validation changes and on-board providers.

- Question (Secretary Polanowicz): The slide says that 40 EDs are required to send data, leaving at least 24. Are there some that are not required to submit this information?
    - Answer (Laura Nasuti): We will look into whether or not it is the number of EDs connecting or the number of legal entities. That may be the discrepancy.
- Comment (John Halamka): The CDC outsourced Information Technology (IT) to Amazon, signed Business Associate Agreements, and set up 56 data center "slots" so that CDC can align across all of the states and territories.

(Slide 14) DPH HIway Nodes: Electronic Laboratory Reporting (ELR) – ELR supports meaningful use stages 1 and 2. A before and after picture of the submission process was provided.

(Slide 15) DPH HIway Nodes: ELR – Right now Beth Israel Deaconess Medical Center (BIDMC) is live with the ELR Node. Here we have improved security of the transmissions and it should provide easier management for the submitting organizations and a single method for connections, using their connection to the HIway, to direct messages to the different [public health] nodes.

(Slide 16) DPH HIway Nodes: ELR - One of the challenges was communication to providers. There is a joint outreach effort for MDPH and the HIway to talk to these providers. Next steps will be to reach out to the providers that are still using HL7 to submit data.

- Question (Mike Lee): At Atrius we send transactions through our ESP network and we have MDPH Net. Are we anticipating that we are going to have to move all of those transactions to the HIway?
    - Answer (Laura Nasuti): The current stance is that Mass HIway should be used for the transport. MDPH Net use for real time query-able data is separate.
- Question (Secretary Polanowicz): With all of these examples, given that the base systems still remain, we are still getting the data while organizations move over to the HIE, correct?
    - Answer (Laura Nasuti): Yes, people are still submitting HL7 transactions to MDPH.
- Question (Karen Bell): Have you been able to quantify the administrative burden?
    - Answer (John Halamka): It is kind of "auto-magical." Providers do not think about it anymore. I have never seen a complaint from anyone and the production system works very well.
- Comment (Manu Tandon): Anyone new coming in [to MDHP reporting] will come through the Health Information Exchange (HIE). We are setting dates as a way to push people along.

(Slide 17) Massachusetts Cancer Registry (MCR) - Here is where we really start to see the simplification. MCR satisfies a meaningful use stage 2 menu item. The real benefit is in moving away from the paper format. Right now DPH has to send data to the CDC and this requires manual intervention to convert it to the right format. Now it is coming right through the HIE from the Electronic Health Record (EHR) into the MCR system and validated for the right data elements.

(Slide 18) MCR - It eliminated the manual process where DPH is currently entering data manually for about 6,000 cancer cases annually. The node is live in production.

(Slide 19) MCR – The major challenge was that vendors are not set up to connect yet. The HIway team is working with Athenahealth now and helping with outreach to their providers.

- Question (Meg Aranow): When I worked in hospitals there were not many EMR's that had the staging criteria to do this, most were working with separate cancer registry products.
    - Answer (John Halamka): It has a very obscure standard for cancer registry submission which basically no EHR vendor has done.
- Question (Laurance Stuntz): How many different hospitals are doing this?
    - Answer (Laura Nasuti): Everyone that has a cancer program.
- Question (Mike Lee): Is the cancer treatment center the one sending the data?
    - Answer (Secretary Polanowicz): If you run an outpatient fusion center you submit as the hospital.
- Question (Mike Lee): What if you have a surgical treatment, but not at the cancer center?
    - Answer (Larry Garber): We had to do that and extracted the data from the EHR.

(Slide 20) Intake Enrollment and Assessment Transfer Service (IEATS) – IEATS is not necessarily helping with meaningful use but there are benefits from use of the HIway. MDPH will collect provider data to evaluate client outcomes and program effectiveness for opioid treatment services. They will then report data to National Outcome Measures (NOMS) as required by the Substance Abuse and Prevention Block Grant. A provider can submit from their EMR through the HIway.

(Slide 21) IEATS – IEATS provides administrative simplification with real time error checking and elimination of redundant data submission. It impacts substance abuse treatment organizations and the node is live.

(Slide 22) IEATS - MDPH is working with vendors to modify their EMR's to meet State requirements/formats.

- Question (Secretary Polanowicz): Do those three EMRs [NetSmart Avatar, Netsmart Tier, Smart Inc] represent the superset of the EMRs used by substance abuse treatment providers in the Commonwealth?
    - Answer (Laura Nasuti): That is my impression.
    - Answer (Laurance Stuntz): There are a few others like eHana. NextGen is used by a lot of community health centers.
- Comment (Robert Driscoll): I think there are quite a few other ones - Netsmart is a decent sized vendor, but I know there are at least four other vendors.
- Question (Patricia Hopkins): Is this just the in-patient rehab/detox facilities?
    - Answer (Laura Nasuti): We are also talking about outpatient facilities and mental health counselling.
    - Comment (Secretary Polanowicz): I think it would be helpful to get more data with the particular focus on opioids and substance abuse. Where is the data? Is it captured in here, or is that a Phase 2? We could do 100% of this and only have it cover a small percentage of the Commonwealth. We need to consider the mental health clinical licenses and more than just detox facilities.
    - Comment (Robert Driscoll): There are a large number of programs that are not just detox. All of those other entities submit a similar amount of data as the Opioid Treatment Program (OTP) clinics. We are doing a pilot with NetSmart to do an interface through the HIway.
    - Comment (Secretary Polanowicz): This may have been the first step to address the universe but there is a whole continuum of treatment there. The question is, can we use the HIE to advance the system. I think the answer is 'absolutely' but it should be some place on the timeline. We spent a lot of time and Full Time Equivalents (FTEs) on this. On the psychiatric hospital side there is really no useful data collection, MDPH doesn't do anything with it, and Massachusetts Department of Mental Health (MDMH) doesn't seem to do anything with it. It is amazing that there is no data collection at all.

(Slide 23) Childhood Lead Poisoning Program (CLPPP)- Providing electronic means to import live lead poisoning data. On the left side there is a more complicated picture than on the right. Before there was manual intervention to convert the data, whereas now they are submitting over the HIway. State labs are using HIway for Electronic Lab Reporting.

- Question (Larry Garber): Can you clarify what they are reporting? Test results?
    - Answer (Laura Nasuti): Blood lead level.
- Comment (Mike Lee): It seems like there is an identity proofing issue. We have the Childhood Immunization Registry then we have a whole separate node. I hope there is some availability to separate those out.
    - Response (Darrel Harmer): The first step was to make the process less labor intensive, then we'll look at what else can be done to further streamline the process.
- Comment (Meg Aranow): It looks like they are looking for the treatment plans more than the lab codes.
    - Response (Manu Tandon): We can take a closer look at this.

(Slide 24) CLPPP - The benefits of automation reduce staff time as well as the rate of errors. Around 60 providers are submitting data through CLPP and the state submits on behalf of the providers as well. The initial node will be introduced in late July/ August.

(Slide 25) CLPPP – It will be a challenge onboarding the 60 providers – MDPH will work with the HIway team to proactively reach out to providers.

(Slide 26) e-Referral- This node was funded by the State Innovation Model (SIM) Grant to support data exchange from a clinical setting to community based organizations such as referring patients to community based services like the YMCA or a tobacco help line. The community based providers would not be their own entities on the HIway because they are not clinical. They would use the webmail functionality to send information to and from.

(Slide 27) e-Referral – This transforms the current system to be fully electronic. Right now the node is under development and we are aiming for a July launch.

(Slide 28) e-Referral – One of the biggest challenges is outreach to providers. A lot of providers in the Prevention and Wellness Trust Fund want to be on right away and it is hard to onboard everyone all at once. Next steps are to complete development and get people onboard starting with the pilot group as well as the Trust Fund sites. The work will be a joint effort between the HIway and MDPH teams.

- Question (Meg Aranow): Does this include social services? Or is that another possible node?
    - Answer (Laura Nasuti): It could be in theory. This is a pilot so we are not that far yet. We are specifically looking at what would be best to focus on now – falls prevention and smoking cessation for example. Within DPH there has been interest in a variety of different program related to early interventions, asthma programs, and school health programs but those are all in preliminary discussions.

- Question (Larry Garber): You said there are two ways of sending the data; one is to use the portal, the other seems to be directed from my EHR. What exactly would I be sending? A CDA document?
    - Answer (Laura Nasuti): Right now we are working with two vendors, Athena and a vendor that supports NextGen on the CCD. We are specifying the elements that go through. Most of it is going to come straight out of the EMR so we are working with vendors to say what is actually going through.
- Question (Meg Aranow): Is there a target date on when the program can come back and show how they are improving interventions and care coordination?
    - Answer (Laura Nasuti): I believe that is something substance abuse is looking to do early on. A large part of the grant is the evaluation. I am not sure for example if the Cancer registry has set anything up to track.
- Comment (Iyah Romm): I think that as this progresses it would be good to get some data on trending and targets, to understand the types of organizations involved, to find out the 5 or 7 top ways to connect, and to identify peoples' top priorities. Do these numbers reflect champions? Or other strategic reasons? Initially this was meaningful use driven and I'm not sure about the evolution.
    - Response (Jim Nally): As the use cases came around we looked at how best to leverage the existing infrastructure. The timing was right for eReferral.
- Question (Secretary Polanowicz): How does the Prescription Monitoring Program (PMP) tie in? I think that is something people are interested in right now.
    - Answer (Laura Nasuti): We have done some initial white boards. We are just not far enough along yet.
    - Response (John Halamka): It may be part of meaningful use stage 3.
    - Response (Secretary Polanowicz): I would look at prioritizing getting the PMP on the HIway.

(Slide 29) Future of HIT (&HIE) in Public Health - We talked about 7 nodes today. Clearly a role of the HIway is improving public health in the state. The HIway is a means of securely and more accurately getting the data. There is the potential for early detection of diseases and Mass HIway allows us to reallocate resources more appropriately.

Discussion Item 2: Massachusetts eHealth Institute (MeHI) Update (Slides 31-40)

See slides 31-40 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Massachusetts eHealth Institute's updates were presented by MeHI Director, Laurance Stuntz.

**Prior to the meeting two documents were distributed to the Council- MeHI Operating Plan and MeHI Strategic Plan*.

(Slide 33) Core Themes – The HIE grant is complete as of last Friday. The implementation of vendor grants has a period of performance that ends this month and they are working on their final report. Things are going into production now that the Health Information Service Provider (HISP) to-HISP connections are coming together, getting more grantees into production. The Regional Extension Center (REC) grant has been extended into this year. There are about 400 providers that still need to meet meaningful use. The Office of the National Coordinator for Health Information Technology (ONC) asked us to set up pilot programs to extend support for meaningful use. MeHI is looking to create services that are not being handled by the market today.

(Slide 34) MeHI Initiatives 2014-2015 – MeHI will focus on four areas- eHealth eQuality, Connected Communities, Meaningful Use Support, and eHealth Cluster Development. We want to make sure the world knows that Massachusetts is the place to come and grow Health Information Technology focused companies.

(Slide 35) eHealth eQuality: Behavioral Health and Long Term/Post-Acute Care –One thing we have heard from Long Term Care and Behavioral Health organizations is that they have no idea where to start. MeHI is helping them understand what vendors are out there and how to procure systems using our own assessments and Customer Relationship Management (CRM) system. We will also launch an incentive program to support adoption and connection to the HIway.

- Question (Larry Garber): Do you anticipate incentives being similar to the optimization program?
    - Answer (Laurance Stuntz): It may very well be. Some do not need this - it will be the smaller organizations that will need the incentive. We do not have the internal expertise to help all of those folks so we would like to contract that out - Someone to do some hand holding.
- Question (Meg Aranow)*:* My understanding is that there are a number of organizations needing help in the post-acute care community. Have we prioritized what those are?
    - Answer (Laurance Stuntz): Our initial focus will take a look at roughly 430-450 skilled nursing facilities.
- Question (Meg Aranow): Usually when people talk about Post-Acute Care they are talking about completely different EHRs. Is the prioritization by complexity or underserved population?
    - Answer (Laurance Stuntz): The program is initially focused on getting the data used at those organizations digital. We will also look at what populations they serve which will also feed into the incentive criteria.
- Comment (Larry Garber): One other concern, the meaningful use program incentive involved very specific EHR certification standards, but those certification standards do not exist here.
    - Response (Laurance Stuntz): It does turn out that there are voluntary standards. I think our preference would be to work with those vendors that are involved in those voluntary standards.
    - Response (John Halamka): You can get a stamp of approval from the vendor. Many of those vendors have already been involved with testing those voluntary standards.
- Question (Daniel Mumbauer): Where will the incentive dollars come from?

- Answer (Laurance Stuntz): About 6.6 million of the overall $28.5 grant for 4 years is targeted at this. Payment will be split into Phase 1 and 2.

We talked a bit about this two meetings ago – the Certified Nurse Specialists ability to get access to meaningful use dollars. There are about 800 in the state, if they all qualified it would be around $60 million available to them, so we have been working with Kris Williams and EOHHS to make sure that happens.

- Question (Robert Driscoll): Any progress on when that might happen?
  - Answer (Manu Tandon): I can get you an update, but it is over 6 months out.

(Slide 36) Connected Communities – Taking a community based approach- working with a lot of the Community Hospital Acceleration Revitalization and Transformation (CHART) hospitals, a lot of these are aligned to have a common way of reporting. Part of this fiscal year will be looking at what to address in those communities. A lot of issues have come up. For example, a hospice program really wants Advance Directives functionality.

(Slide 37) Meaningful Use Support- Includes the Medicaid incentive application. I think we are very close to finalizing and are close to renewing with Health and Human Services (HHS) for a year. This includes the completion of the REC and the extension of the meaningful use services.

(Slide 38) eHealth Cluster Development- The goal is to encourage economic development in Massachusetts. There is a lot of excitement in the business community. We do not have a lot of dollars to put into it but MeHI funded one FTE to do this.

(Slide 39) Financial Overview – There is a lot more detail in the Word documents sent to the Council. A four year horizon of expenditure and financial assistance by year was provided. There are some other expected revenue sources: Chapter 224 funding, Federal funding, Medicaid, Portal membership fees, and event fees.

(Slide 40) Key Questions – There are some key questions we need to dive into - MeHI will be looking to the Council for any feedback on the operating plan and initiatives.

Discussion Item 3: Mass HIway Update (Slides 41-52)

See slides 41-52 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Mass HIway updates were presented by Manu Tandon, Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator.

(Slide 42) HIway Release Schedule – There is one change from the last update; the Healthcare Provider Portal Release 1 has moved from June to July. *(Slide 43) Communications & Outreach* – EOHHS completed one webinar on July 17th. The next will be in August. Once we have done a few of these we will bring back some feedback and information for the Council.

- Question (Deborah Adair): How did it go?
    - Answer (Manu Tandon): It went well, people asked good questions about the cost and technical complexity, and 75% indicated they would join the HIway in 2014.

(Slide 44) HIway Operations Update – May was a great month. 7 new Participation Agreements (PAs) were signed bringing the total to 205.

(Slide 45) HIway Operations Update- May saw organizations 55 go live including Winchester Highland. There are 159 overall live connections.

(Slide 46) HIway Operations Update- A list of members of the eLINC HISP was provided.

(Slide 47) HIway Operations Update – The volume continues in the same pattern. The spike in May 2013 was because of testing around Phase 2 with Holyoke- This brings us to over 2.6 million total transactions.

(Slide 48) HIway Operations Update – Our goal for the [state fiscal] year was to connect 135 organizations and we are projected to get to 170. I want to pause and thank Partners, Orion, MAeHC, MEHI and the EOHHS team! Great work!

(Slide 49) EHR Vendor Readiness - The only change on the scorecard is with Athenahealth- they graduated from enrolling to testing. We will bring the dashboard back to each meeting and show the progress.

(Slide 50) HISP to HISP Connectivity- This is a large focus for EOHHS and June is a big month. We hope to see 6 more HISPs connect by year end.

(Slide 51) Operational Maturity in HISP-HISP Transaction Management – We are evolving the HISP- to -HISP model. As you may recall we talked about doing a Whitelist. We were keen on coming up with a one size fits all model. We knew we could solve the authentication issue and wanted to have the providers behind the HISP sign the PA to solve for authorization. We would have the providers on the White list and know who they are. As this has evolved we have realized we need a two tiered model where we will keep the white list for some trading partners and not use it for others. We would no longer require the participants behind a HISP to sign a PA. The downside is the example of a rogue person sending documents from Texas to someone on the HIway. To combat this situation the HIway will create a "Black list" and filter out bad actors. This decision is a result of 4-5 months of working with different stakeholder groups and with the HISP's.

- Question (Claudia Boldman): Can we do that without the Direct federation framework- trusting that the HISP has vetted their participants?
    - Answer (Manu Tandon): Our model went beyond the federal Direct standards. We worried about non-participants having access to the HIE. We have also found that Surescripts has guaranteed message delivery and that our White list would be an issue for them.

  - Comment (John Halamka): HISPs have some onboarding processes. It is not asking about good people or bad people, it is about making sure members are who they say they are. We have a 10% Transition of Care requirement for meaningful use to meet. The meaningful use meter measures how many messages you send, not who receives it. What if we had 100 providers in Texas trying to get meaningful use credit. We would end up Black Listing them. I think the model is very consistent with Direct. Our query response is different. It will be very specific and the guy in Texas will not be able to query.
  - Comment (Manu Tandon): I think the White list was an additional check that did not make sense for national players.
- Question (Larry Garber): In terms of the Provider Directory are we going to expose the Surescripts directory in ours?
  - Answer (Manu Tandon): Yes- I think we will still ask for their provider list. Four years back we felt that the Provider Directory was going to be the thing in the center. Now I feel it will be more federated approach.
  - Response (John Halamka): They are still working on the standards for that. It is the same thing as email; how do I know Laurence's address? Because it pops up when I start to type. I do not go into a MeHI directory to find it.

(Slide 52) Phase 2 Implementation Plan- Work continues on the Phase 2 implementation. Beth Israel Deaconess Medical Center (BIDMC) printed the forms and they are getting distributed to other hospitals. Holyoke had a setback - they are reevaluating a move to Local Access Network Device (LAND). Tufts is testing aggressively. Right now they are batch testing and getting ready for volume testing.

- Comment (John Halamka): We have patient and engagement council which attracts very passionate and interested parties. They will attend a Continuing Medical Education (CME) session put on by me, explaining the Mass HIway - all policies, consent, all of that good stuff! I will bring feedback.

Discussion Item 4: Wrap-Up (Slide 54)

See slide 54 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Wrap-up presented by Manu Tandon

The schedule for the 2014 HIT Council Meetings was provided.

- ~~January 13~~
- ~~February 3~~
- ~~March 3~~
- ~~April 7~~
- ~~May 5~~
- ~~June 9~~

- July 7
- August 4
- September 8
- October 6
- November 3
- December 8

** All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21th floor, in the Matta Conference Room.*

The Next HIT Council Meeting is scheduled for July 7 from 3:30pm-5pm at One Ashburton Place, 21th floor, in the Matta Conference Room. If that date does not work please communicate that to Manu.

The HIT Council meeting was adjourned at 4:50 P.M.